



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 3 2 1 8 7

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <u>H. Chester Bloomfield</u>		2a. DATE OF DEATH MONTH DAY YEAR HOUR <u>December 8 1981 1:50A</u> M	
3. SEX <u>Male</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>October 4, 1906</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>75</u> YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Philadelphia, Pd.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Caroline</u> MD.
10. CITY OR TOWN OF DEATH <u>Denton</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Caroline Nursing Home</u>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Farmer</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u> 13b. COUNTY <u>Caroline</u> 13c. CITY OR TOWN <u>Preston</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <u>Main Street</u>
14. FATHER'S NAME FIRST MIDDLE LAST <u>Herbert William Bloomfield</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Anna McLaughlin</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>188-14-4414</u>	
17. INFORMANT <u>Marion W. Bloomfield, Box 2, Preston, Md.</u>		ADDRESS <u>21655</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> <u>5850</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>GENERALIZED Debility and weakness</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>RENAL FAILURE</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>chronic</u> <u>chronic</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Generalized arteriosclerosis, PARKINSONISM</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/2</u> 19 <u>81</u> , to <u>12/8</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>12/6</u> 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Christian E. Jensen MD</u>		22c. DATE SIGNED <u>12/08/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Christian E. JENSEN MD</u>		22e. ADDRESS <u>Christian E. Jensen MD</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>Dec. 10, 1981</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Junior Order Cemetery</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>Preston, Caroline, Maryland</u>
24. FUNERAL DIRECTOR NAME <u>Frampton-Hawkins Funeral Home</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC 11 1981</u>	
ADDRESS <u>216 N. Main St.</u>		25b. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>	

12

Washington, D.C.

Department of State

4-25-53



U.S. DEPARTMENT OF STATE  
OFFICE OF THE SECRETARY  
WASHINGTON, D.C.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 3 2 1 8 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Florence Elderdice</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 18 81</b>		2b. HOUR <b>10:00A.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>November 14, 1908</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		8. IF UNDER 24 HRS. HOURS MIN. <b>MD.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Caroline</b>						
10. CITY OR TOWN OF DEATH <b>Denton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Caroline Nursing Home, Inc.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Caroline</b>		13c. CITY OR TOWN <b>Federalsburg</b>		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 2, Box 218</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Cahall</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Stella Scott</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>222-12-2221</b>		17. INFORMANT ADDRESS <b>Maryland 21632</b>		
17. Mrs. Marie Todd, Rt. 2, Box 218, Federalsburg						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ACUTE</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <b>DIABETES MELLITUS, DEMENTIA, S/P RECENT HIP FRACTURE, OPEN WOUND</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>8/1/81</b> to <b>12/1/81</b> , that (I) (we) last saw the deceased alive on <b>12/1/81</b> 19 <b>81</b> (and that in my) (our) opinion death occurred on the date and hour and from the causes stated above. (and did not view the body after death.)						
22b. SIGNATURE <b>Christian E. Jensen MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>12/18/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Christian E. JENSEN MD</b>		22e. ADDRESS <b>Box 690, Kerr Ave, Denton MD 21629</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 21, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Federalsburg, Caroline, Md.</b>						
24. FUNERAL DIRECTOR NAME <b>Freemont-Stanley</b>		ADDRESS <b>Box 43 Federalsburg, Md 21632</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 23 1981</b>		
25b. REGISTRAR'S SIGNATURE <b>Rene J. [Signature]</b>						

BP

October 11, 1972

Dear

John

Enclosed is a copy of the letterhead memorandum

dated and captioned as above.

Very truly yours,

W. J. Brennan  
Director

W. J. Brennan  
Director

W. J. Brennan  
Director

W. J. Brennan  
Director

W. J. Brennan  
Director

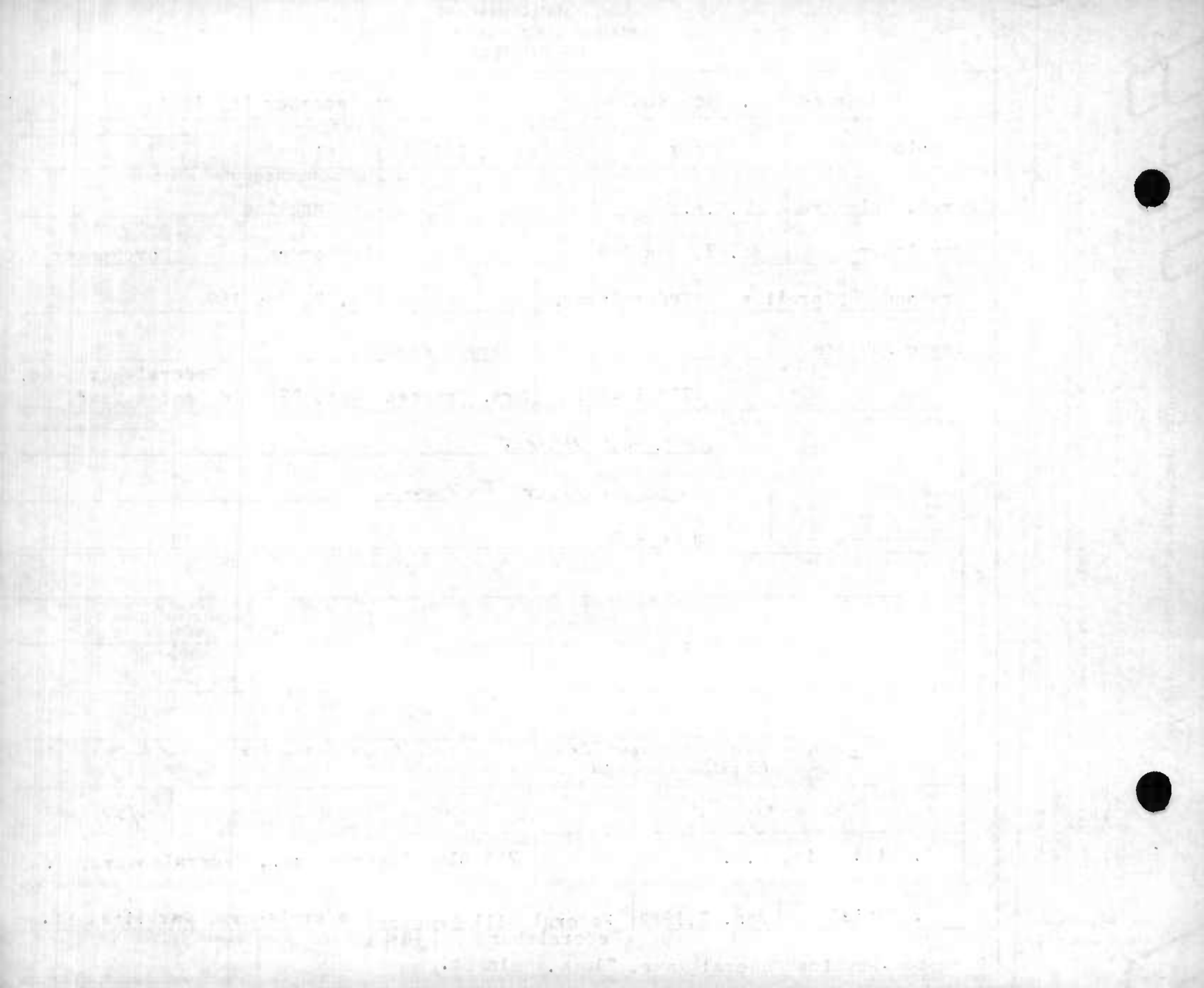
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Ernest L. Johnson			2a. DATE OF DEATH December 26, 1981				2b. HOUR A.M.			
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH August 8, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Laurel, Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Caroline MD.				
10. CITY OR TOWN OF DEATH Federalsburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 2, Box 169				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lumberman		12b. KIND OF BUSINESS OR INDUSTRY Dorchester L.C.		
13a. STATE Maryland			13b. COUNTY Caroline		13c. CITY OR TOWN Federalsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 2, Box 169	
14. FATHER'S NAME Isaac Johnson					15. MOTHER'S MAIDEN NAME Mary Anderson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WWII 213-18-5819A		17. INFORMANT ADDRESS Mrs. Frances Hunt, 220 Old Denton Road, Federalsburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/24/81</u> , 19 <u>79</u> , to <u>12/23</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>12/23</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE S. Willy Lin, M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/28/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Willy Lin, M.D.			22e. ADDRESS 215 Bloomingdale Ave., Federalsburg, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 2, 1982		23c. NAME OF CEMETERY OR CREMATORY Federal Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Federalsburg, Caroline, Md.			
24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home, 216 N. Main St.			ADDRESS Federalsburg		REGISTRAR'S SIGNATURE JAN 4 1982					

BP





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Alethia C. Richardson</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>12 29 19 81</b>			2b. HOUR <b>M</b>		
3. SEX <b>Female</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 25, 1909</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>72 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>12 29</b>	IF UNDER 24 HRS. HOURS MIN. <b>19 81</b>	2c. DATE PRONOUNCED DEAD <b>12 29 19 81</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgetown, S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Caroline</b> MD.		
10. CITY OR TOWN OF DEATH <b>Federalsburg</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>127 Smith Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Food processor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>King Cole</b>
13a. STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Caroline</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>127 Smith Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arthur T. Grant</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Irene Hayward</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		
16b. SOCIAL SECURITY NO. <b>248-07-6530</b>			17. INFORMANT ADDRESS <b>John Richardson, 127 Smith St., Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovasc dis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>chronic</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>acute</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>CARCINOMA OF PANCREAS</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Christian E. Jensen</b>			TITLE (SPECIFY) <b>Deputy</b>			DATE SIGNED <b>12/30/81</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Christian Jensen, M.D.</b>			ADDRESS <b>Denton, Maryland 21629</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Jan. 2, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Federal Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Federalsburg, Caroline, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Framptom-Hawkins Funeral Home</b>			ADDRESS <b>216 N. Main St.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1982</b>			



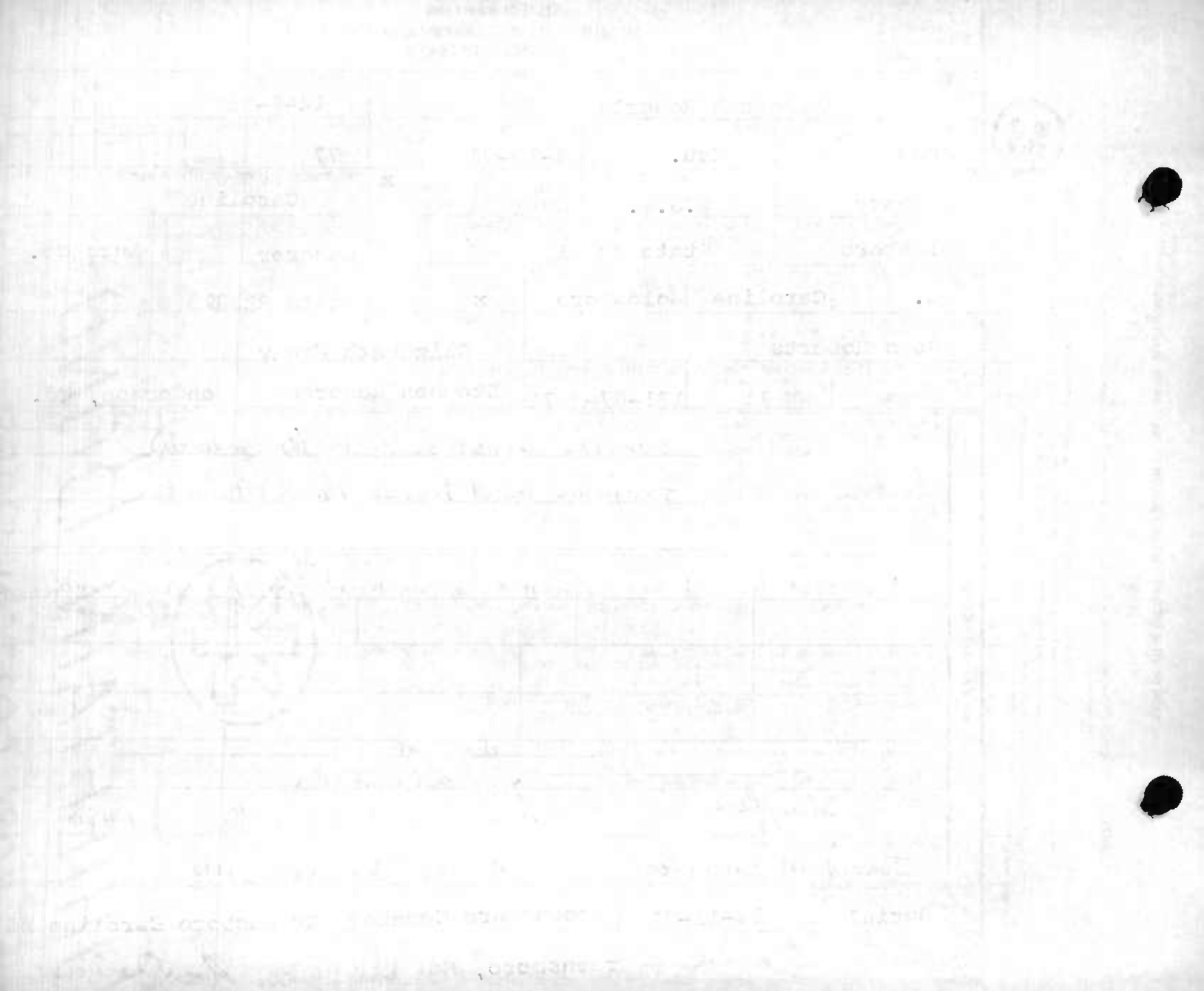


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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				7 1 3 2 1 9 1			
1. DECEASED NAME (TYPE OR PRINT) <b>Joseph Roberts</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>12-9-81</b>		2b. HOUR <b>8 A M</b>	
3. SEX <b>male</b>		4. RACE <b>Cau.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3-10-04</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN <b>77 YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Hungary</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Caroline</b> MD.	
10. CITY OR TOWN OF DEATH <b>Goldsboro</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>State Rt 313</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Auto Co.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN <b>Md. Caroline Goldsboro</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>State Rt 313</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Roberts</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Nanay</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>yes WW 11</b>		16b. SOCIAL SECURITY NO. <b>131-07-0871</b>		17. INFORMANT ADDRESS <b>Stephen Roberts Henderson, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest, suspected (sudden death)</b> <b>4149</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ischemic Heart Disease, Atrial Fibrillation</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Metastatic adenocarcinoma of sigmoid ① Hx of systemic emboli</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/9, 1981</b> , to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <b>Never seen him alive</b>							
22b. SIGNATURE <b>J. Shaffer</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/9/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph M Shaffer</b>				22e. ADDRESS <b>Box 122 Goldsboro, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-11-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greensboro Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Caroline Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Wm C Bond</b>				ADDRESS <b>Greensboro, Md</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 14 1981</b>	
				25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

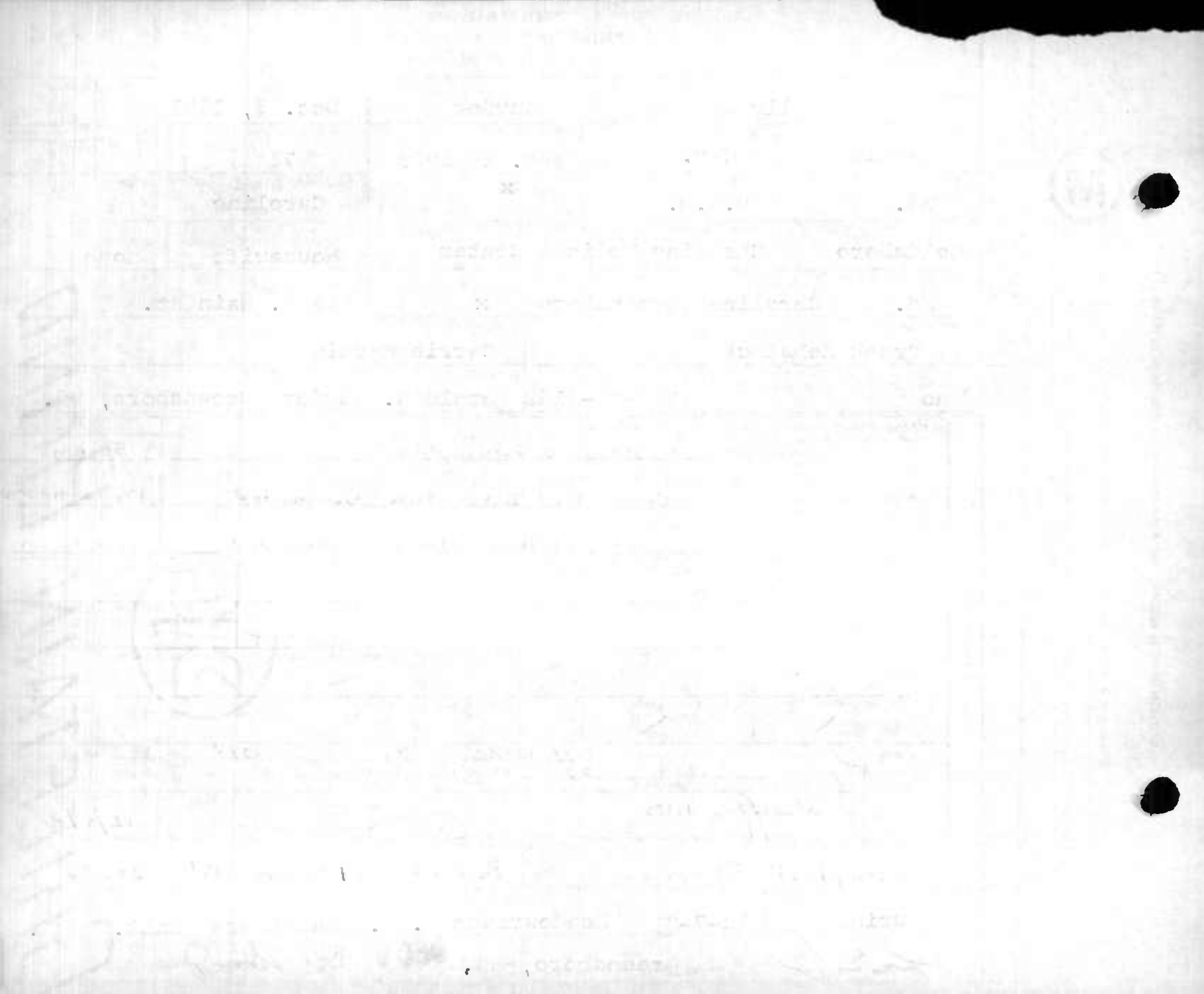
1 - STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Sally Snyder			2a. DATE OF DEATH MONTH DAY YEAR Dec. 3, 1981			2b. HOUR M				
3. SEX female		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR Sept. 24 1909		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Caroline MD.				
10. CITY OR TOWN OF DEATH Goldsboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Caroline Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY none		
13a. STATE Md.			13b. COUNTY Caroline		13c. CITY OR TOWN Greensboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 113 N. Main St.	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Rebstock					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Martin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-01-2162		17. INFORMANT ADDRESS Harold E. Snyder Greensboro, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction, suspected</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ischemic Heart Disease, presumed.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 50 mins 1 1/2 - 2 hours unknown		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <u>Hypertension</u>										
19a. DATE OF OPERATION -			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/3 10:30</u> , 19 <u>81</u> , to <u>12/3</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>12/3</u> , 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE J. Shaffer MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/5/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph M. Shaffer					22e. ADDRESS Box 122 Greensboro, Md. 21636					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-7-81		23c. NAME OF CEMETERY OR CREMATORY Meadowridge M. P.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Balt. Md.			
24. FUNERAL DIRECTOR NAME John E. Bowling					25. DATE REC'D. BY REGISTRAR DEC 9 1981					
ADDRESS Greensboro, Md.					25b. REGISTRAR'S SIGNATURE Anne Gantner					

may be retained by the hospital or attending physician.

should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

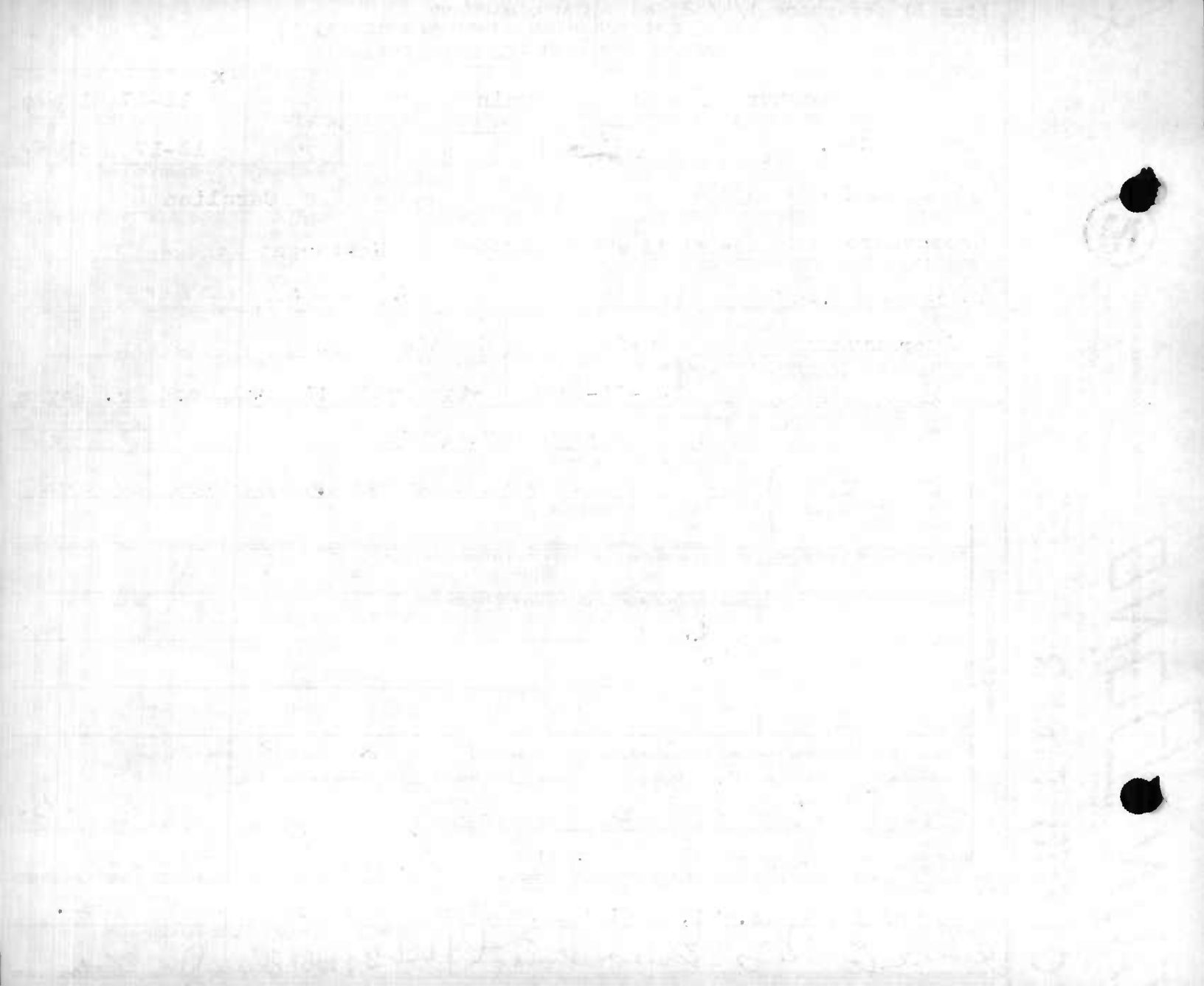
BP

DMMH-17  
(VR A15 ME (5))  
30M 7/73

Item 11 per phone 1/4/82 dad  
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2b. DATE OF DEATH		KNOWN ESTIMATED		MONTH DAY YEAR		2d. HOUR	
Lester Elmer Swain				2b. DATE OF DEATH		KNOWN ESTIMATED		MONTH DAY YEAR		2d. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.	
male		Cau.		6 03 1902		79		MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
DELAWARE		USA		MARRIED		NEVER MARRIED		Caroline		Greensboro	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
in field while hunting		Resturant Manager									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
DELAWARE		KENT		DOVER		YES		14 SMALLWOOD DRIVE			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
Elmer Swain		Mattie Riggs Swain									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		222-14-6296		Betty Swain		14 Smallwood Dr. Dover					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
4100		IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION		acute							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		(b) ARTERIOSCLEROTIC Cardiovascular disease		chronic							
		(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
				YES		NO					
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION							
WHILE AT WORK				CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on		Autopsy		Inspection		Inquiry		and in my opinion			
death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED							
Christian E. Jensen		M.D. DEPUTY		12/17/81							
EXAMINER'S NAME		ADDRESS									
Christian E. Jensen M.D.		Box 690, Denton MD 21629									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. STATE			
Burial		Dec. 21		1981 Odd Fellows		Camden		Kent		Del.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
John E. Bouais		DEC 24 1981		James E. Nathan							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Alois ZUEGER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12 6 81</b>		2b. HOUR <b>4:50P</b> M
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 28, 1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Switzerland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Caroline County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Denton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Caroline Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Builder</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Boats</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Caroline</b>	13c. CITY OR TOWN <b>Denton</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>Hobbs Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alois Zueger</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maria Furrer</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1920-21 171-10-0259</b>	17. INFORMANT ADDRESS <b>Mrs. Margaret Zueger, Denton, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia b. h. t. m. l.</b> <b>4850</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Anterior dissection of aorta</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>3/25/81</b> , 19____, to <b>12/6/81</b> , 19____, that (1) (we) last saw the deceased alive on <b>12/31/81</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Philip P. Feipe MD</b>		DEGREE		22c. DATE SIGNED <b>12/7/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Philip P. FEIPE MD</b>		22e. ADDRESS <b>421 South Fifth Ave., Denton, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/8/81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery Denton</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Caroline Md.</b>
24. FUNERAL DIRECTOR NAME <b>MOORE FUNERAL HOME</b>		ADDRESS <b>DENTON</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 14 1981</b>	
				25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>	





5/8/51